MASI Documentation Guidelines

Applicants must provide documentation, which will be evaluated on a case-by-case basis, according to guidelines of DS. These guidelines are based upon the description of quality documentation of a disability by the Association of Higher Education and Disabilities (AHEAD) and the College Board. Documentation must include a comprehensive assessment administered within the last three to five years by a person with appropriate professional credentials (e.g. a psycho-educational, neuropsychological, or psychological evaluation by a licensed psychologist or psychiatrist) who has undergone relevant training and has no personal relationship with the individual being evaluated. The ideal assessment would include:

- Discussion of the individual’s functional limitations, and current functioning as it impacts ability to participate in the university’s educational programs and services.
- A clear diagnostic statement that identifies and follows DSM-IV-TR or DSM-V criteria.
- An interview including a description of the presenting problem(s) including any significant developmental, medical, psychosocial, and employment issues; family history; current level of adaptive/daily living skills; discussion of comorbidity where indicated; and relevant information regarding the individual's academic history. (A comprehensive summary/interview with both parents, if possible, and a self-report is needed to get a view of the student's present functioning and ability.)
- Discussion of behavioral, social, and communication issues.
- Standardized measures of cognitive development, academic achievement, information processing, and current social/emotional functioning (if not in neuropsychological or psychological evaluation, this can be administered by a separate evaluator).
- A description of the diagnostic methodology used that includes description of the diagnostic criteria, evaluation methods, procedures, tests and dates of administration, as well as a clinical narrative, observation, and specific results.
- An integrated narrative summary, to include current symptomatology, treatment, and ongoing needs. Summary must include impact of symptoms on learning, ability to function, and deficits as related to postsecondary education.
- Information on expected changes in the functional impact of the condition over time and context.
- A description of current and past accommodations, services, and/or medications (to include any possible side effects that may influence the learning environment).
- Recommendations for accommodations, assistive services, assistive technology, compensatory strategies, and/or collateral support services. It is helpful when recommendations are logically related to functional limitations, or if connections are not obvious, a clear explanation of their relationship can be useful in decision-making.

Additional guidelines:

- Accommodation needs change and are not always identified at the time of initial diagnosis. A prior history of accommodation, without documentation of current need and consistent use, does not demonstrate eligibility for accommodations.
- While doctor’s notes and school plans such as an IEP or 504 Accommodation Plan may be helpful in determining a student’s needs, they alone are not sufficient to substantiate a request for program services and accommodations. Conclusive statements without supporting information are unhelpful.
- Additional information, such as survey forms and direct teacher observation, can be included.